

SECTION 1

GENERAL ADMINISTRATION

Eligible Participants

Full-time employees of the following agencies who contribute to one of the state-sponsored retirement systems are eligible to participate:

- State Agencies;
- Boards of Education;
- Health Departments;
- Kentucky Community Technical College System (KCTCS);
- Quasi Agencies

Retirees, under age sixty-five (65), who draw a monthly retirement check from any of the following retirement systems are eligible to participate:

- Kentucky Retirement Systems (KRS)
 - County Employees Retirement System (CERS)
 - Kentucky Employees Retirement System (KERS)
 - State Police Retirement System (SPRS)
- Kentucky Teachers' Retirement System (KTRS)
- Judicial Retirement Plan
- Legislators Retirement Plan

NOTE: For purposes of this Administration Manual, the term "employee" includes retirees and/or beneficiaries.

Other eligible participants

- Eligible COBRA participants

An employee, retiree or COBRA participant and/or his/her dependents may only be covered under **one** state-sponsored plan.

Dependents of any of the above classified employees, which meet the following dependent eligibility requirements, are eligible for participation under the employees plan.

Dependents

A dependent is a person other than the member who is more specifically defined as:

- A member's spouse under an existing legal marriage;
- Any unmarried children from birth to age twenty-four (24) (the age limit) who reside with the member in a parent-child relationship and who are dependent on the member for more than 50% of their maintenance and support. Eligible dependent children are covered to the end of the month in which they turn twenty-four (24). For purposes of determining eligibility for dependent coverage, the term "child" includes (1) natural (biological) children, (2) stepchildren by a legal marriage, (3) children legally placed for adoption with, or legally adopted by, the member, (4) children, including foster children, for whom legal guardianship has been awarded, and (5) grandchildren who are considered dependents for federal income tax purposes. Also classified as a dependent child is a child for whom the member or his/her spouse has a legal obligation under a divorce decree, court order, or administrative order to provide for the health care expenses of the child.
 - A dependent that becomes ineligible to participate in the Public Employee Health Insurance Program and is dropped from the employee's plan can establish his/her eligibility at a later date and be added to the employee's coverage, if all of the following apply:
 - the dependent must be an unmarried* child, stepchild, adopted child or foster child;
 - he/she must be under the age of twenty-four (24);
 - he/she must be dependent on the employee for more than 50% of his/her maintenance and support; and
 - he/she must live in the employee's household in a parent-child relationship.

The employee must complete the Re-establishing Dependent Eligibility Form (see Appendix C-4)

*An unmarried child is a child that has never been married. A divorced child is not considered an unmarried child.

- Dependents may only be covered under one state-sponsored plan. Unless both employees agree in writing, the employee with custody shall have first option to cover the dependent children.
- Eligibility may continue past the age limit for unmarried children covered under the plan who are totally disabled and unable to work to support themselves due to a mental or physical disability that started before the age limit and is medically certified by a physician. The Carrier may require proof of such dependent's disability no more than once a year. A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a dependent from engaging in substantial gainful activity and can be expected to result in death or to be of continuous or indefinite duration. The Carrier must approve total disability.

Eligibility Requirements for Employer Contribution for Insurance Benefits

State Agencies

In order to be eligible to receive the employer contribution, an employee must meet one of the following:

- Full-time employees are eligible for the employer contribution for health benefits for the following month if he/she uses any combination of workdays and paid leave and/or Family Medical Leave Act (FMLA) leave within a month (refer to Section 7 for additional information on FMLA leave).
- When an employee is unable to work and elects to use paid leave or FMLA leave to qualify for the employer contribution for health benefits, he/she shall use those days consecutively.
- An employee returning from leave without pay (LWOP) must work at least one day in the month to qualify for the employer contribution for the following month (refer to Section 7 for additional information on LWOP).
- An employee who has exhausted paid leave and FMLA leave shall not qualify for the employer contribution for health benefits unless he/she works at least one day in the previous month.

All Other Employers

Insurance Coordinators for Boards of Education, Health Departments, Quasi-governmental and other agencies may need to refer to their administrative regulations or internal policies if there is a discrepancy.

Dual Employment

An employee who works full-time for different agencies (i.e. school board and a state agency) and meets the eligibility requirements for both employers is eligible for the employer contribution toward health benefits from both employers.

An employee is only eligible **for health insurance coverage** under one state-sponsored plan.

Therefore, a dual employee may take health insurance through one employer and waive coverage through the other employer and deposit that contribution into a Health Care Flexible Spending Account, where available.

Levels of Coverage

Single – Covers an employee only.

Parent Plus – Covers an employee and one or more eligible children; does not cover the spouse (dependent information must be provided on the application).

Couple – Covers an employee and his/her spouse; does not cover eligible children (spouse information must be provided on the application).

Family – Covers an employee, spouse and one or more eligible children (dependent information must be provided on the application).

Levels of Payment

Monthly – Health Insurance premium is deducted from the last paycheck of the month.

Twice Monthly – Health Insurance premium is deducted equally from both paychecks, if applicable. (If employee fails to choose a payment option, the premiums will be deducted twice monthly).

Cross-Reference – The participating employer's contribution for the Health Insurance premium for both eligible spouses is applied toward one family or couple plan, with the remaining premium deducted equally from each spouse's paycheck.

Cross-Reference Requirements

Married employees choosing family coverage may cross-reference for premium purposes. Both employees are entitled to receive the employer contribution. The additional cost of covering family members is the employees' responsibility. Both spouses must complete applications indicating a cross-reference contract. Any additional premium beyond the employer contribution for family cross-reference coverage will be split between the two spouses and deducted from their checks. The same is true for two employees who wish to cross-reference for couple coverage.

Active employees may cross-reference with a spouse who is under age sixty-five (65) and receiving a retirement check. The cross-reference premium will be split between the active employee and the retiree. In the case of an active employee cross-referencing with a hazardous duty retiree, the active employee's agency will make the entire employer contribution, with the retirement system then making a contribution up to the maximum allowable contribution for that type of coverage. If the total cost is not covered, the remaining amount will be split between their checks. Both spouses must complete applications and indicate cross-reference.

Both husband and wife must be eligible for state-sponsored health insurance from one of the following groups:

- State Agency
- Board of Education
- Health Department
- KCTCS
- Members of additional groups whose employers pay into a state-sponsored retirement system and have elected to participate in the Public Employee Health Insurance Program
- Kentucky Retirement System members under age sixty-five (65)
- Kentucky Teachers' Retirement System members under age sixty-five (65)

Both husband and wife must:

- complete an application requesting either couple or family (and indicate cross-reference);
- elect coverage in the same county;
- be covered by the same health insurance plan; and
- be covered at the same level of coverage.

NOTE: Participants of the Judicial and Legislators Retirement Plans are NOT eligible for cross-reference. An employee may not cross-reference with him/herself.

If an employee and his/her spouse are cross-referenced and one of the employees leaves employment, the total cost for the employee portion will be deducted from the remaining employee's check. This is not a Qualifying Event to change the level of coverage.

Employees who marry during the year and wish to cross-reference

When two employees, enrolled in different plans, marry during the plan year, one of the employees will be allowed to change to the other spouse's plan so they may cross-reference. An application indicating this change must be made no later than thirty (30) days after the marriage. Both spouses must complete a new application. All other cross-reference requirements must be met.

An employee's spouse becomes eligible for the Public Employee Health Insurance Program

The employee, whose spouse becomes eligible for participation in the Public Employee Health Insurance Program, will now be eligible to cross-reference with the new employee. The new employee will have to choose the same plan as the current employee. An application indicating this change must be made no later than thirty (30) days after the employee is hired. Both employees must complete a new application. All other cross-reference requirements must be met.

An employee's spouse is employed with a group that begins participation in the Public Employee Health Insurance Program

An employee whose spouse's employer begins participation with the Public Employee Health Insurance Program will have to wait until an Open Enrollment period or when a federally recognized status change occurs during the plan year to begin cross-referencing.

Initial Enrollment

An employee must complete an application, but no physical examination is required. Coverage will begin on the first day of the second calendar month following the month in which an employee begins employment (hereinafter referred to as the first day of the second month rule). For example, if employment begins in August the employee is eligible for coverage October 1.

New employees must apply for coverage or waiver of coverage within the first thirty (30) days of employment. Failure to do so will result in automatic assignment to the lowest cost Single Option A plan offered in his/her county of residence.

Note: Insurance Coordinators of Quasi-Governmental and other agencies need to refer to their administrative regulations or internal policies if said groups have a probationary period for benefit eligibility. The employee must sign the Health Insurance application thirty (30) days prior to the effective date of coverage. Failure to do so will result in automatic assignment to the lowest cost Single Option A plan offered in his/her county of residence.

County Selection

An employee participating in the Public Employee Health Insurance Program has the opportunity to select coverage in the county in which he/she lives, works, or if applicable, a contiguous county. See below for an explanation of the contiguous county availability.

Contiguous County Selection

Legislation was passed during the 2002 Regular Legislative Session allowing an employee who lives and works in certain counties (referred to as contiguous counties) an additional choice in selecting his/her health insurance coverage.

Read the following section carefully as it does not apply to all counties in the Commonwealth:

- A contiguous county is a county in Kentucky that shares any portion of its border with another county within the Commonwealth of Kentucky listed in the "Contiguous County" chart (refer to Appendix B-4).
- If an employee lives and works in any of the contiguous counties listed in the Contiguous County chart (refer to Appendix B-4), he/she may select his/her

coverage in that county or in the county listed directly to the right that is highlighted.

Open Enrollment

During Open Enrollment each year, employees may elect to change plans. The employee is permitted to make any other type of change without incurring waiting periods for pre-existing conditions if they have been covered for the past twelve (12) months by prior creditable coverage. When adding dependents, a pre-existing condition may apply. However, credit will be given on a month-by-month basis (toward satisfying the twelve (12) month waiting period) for any prior creditable coverage, as long as there has been less than a sixty-three (63) consecutive day break in coverage between the termination of that coverage and the effective date of coverage with the Public Employee Health Insurance Program.

Coverage Changes

An employee signing a waiver of coverage when he/she is eligible under the Public Employee Health Insurance Program cannot enroll until the next Open Enrollment period unless he/she experiences a change in family status or a special enrollment right pursuant to the provisions of the Health Insurance Portability Accountability Act (HIPAA).

Whenever there is a change in the family status as defined in the federal regulations, an employee must submit a new enrollment application according to the Qualifying Event Chart in Section 3. Failure to report changes in a timely manner may result in a loss of benefits. If an employee does not apply for the change within the designated time period, he/she must wait until the next annual Open Enrollment period.

Coverage Terminations

Termination of Employment

An employee carrying health insurance coverage who terminates from the Public Employee Health Insurance Program will be covered until the end of the month following his/her month of termination subject to the following provisions:

- If an employee chose a plan with a premium greater than the lowest cost Single Option A plan, he/she must continue to pay his/her portion through the month following termination. The premium will be deducted automatically from the employee's check. In the event there is not enough money in the last paycheck to cover the premium, agencies should collect from the individual or deduct the remainder from the payout of vacation or compensatory pay.
- If an employee terminates before his/her benefits take effect, the employee will not be eligible for COBRA.

Death of Employee

The employer contribution for health insurance will end the month of the employee's death. If the next month's contribution has been made, a refund must be requested.

At the time of death, the Insurance Coordinator should notify the family, in writing, of the following:

- date the last paycheck will be issued;
- contact information for the appropriate retirement system;
- name and phone number of health insurance carrier;
- COBRA notification letter;
- Flexible Spending Account information and phone number (if applicable); and
- any additional employee payroll deductions and company contact.

Loss of Dependent Eligibility

Refer to the Qualifying Event chart in Section 3 for the termination dates resulting from Qualifying Events.

Retro Activity Related to Premium

Terminations:

Any mid-year election resulting in the termination of a covered person will be effective on the date as designated under the terms of the Public Employee Health Insurance Program. If the OPEHI receives notification of a termination more than ninety (90) days after the event causing the termination, premium will be refunded as shown in the following table:

Notification received within the month of:	Count From:	Months for which Premium is to be refunded:
January	January 31	January
February	February 28	January and February
March	March 31	January, February and March
April	April 30	February, March and April
May	May 31	March, April and May
June	June 30	April, May and June
July	July 31	May, June and July
August	August 31	June, July and August
September	September 30	July, August and September
October	October 31	August, September and October
November	November 30	September, October and November
December	December 31	October, November and December

Overpayment Requirements

Carriers are required to issue refund checks for any erroneous overpayments. These checks will be made payable to:

1. The Kentucky State Treasurer, if the overpayment is to the employer;
2. The employee, if the overpayment is the employee's share; or
3. Separate checks for both the employee and the Kentucky State Treasurer, if there is an overpayment of both employee and employer payments.

Refund checks will be sent to the appropriate Insurance Coordinator or Payroll Officer no later than thirty (30) days of receipt of the request for refund.

Either the Insurance Coordinator or the Payroll Officer should initiate the request for such refunds. The following list, while not all-inclusive, defines when a refund may be requested:

1. A check is issued in error;
2. An employee terminates at the end of the month and one-half the premium is deducted and sent to the Carrier;
3. An employee is enrolled with the wrong carrier or wrong plan type, option level, or coverage level;
4. The occurrence of Qualifying Events, since the Commonwealth is a pre-paid health plan; or
5. An employee is ineligible or becomes ineligible.

Do not take premium credits from your agency account in lieu of refunds.

Refunds will be restricted to the beginning of the current plan year to a maximum period of three (3) months or ninety (90) days, except in the event of the death of a covered person. Premium refunds will be given to the date of death of any covered person.

Grievance Procedures

Appeals to the Plan

If an employee is dissatisfied with any action or failure to act on the part of the carrier, he/she should file an appeal through the Carrier's grievance procedure. Each carrier administers its own grievance procedure(s), which are described in each carrier's Certificates of Coverage. For additional information, contact the Carrier's Customer Service Department or refer to the Department of Insurance website (<http://www.doi.state.ky.us/kentucky/>).

Appeals to the Public Employee Health Insurance Program's Grievance Committee

If an employee is dissatisfied with any action or failure to act in connection with eligibility for enrollment or disenrollment, he/she may file an appeal to the Public Employee Health Insurance Program's Grievance Committee no later than thirty (30) calendar days of the event or notice of the decision being protested.

The employee must file appeals in writing to:

Personnel Cabinet
Office of Public Employee Health Insurance
Public Employee Health Insurance Program
Grievance Committee
200 Fair Oaks Lane, Suite 502
Frankfort, KY 40601

A written response will be mailed to the employee stating the decision of the Committee. **All decisions by the Committee are final.**

Appeals must include all of the following:

- a statement specifically describing the issues disputed by the employee;
- a statement of the resolution requested by the employee; and
- any other relevant information.

The Committee will not review a second request unless additional relevant facts are provided.

Fraud

If a Carrier believes that any fraudulent activity has occurred, the Carrier is authorized to investigate and pursue resolution of any such activity.

Double Dipping

KRS 18A.225 prohibits an employee who is eligible for and participating in the Public Employee Health Insurance Program as a retiree, or the spouse of a retiree, under any of the state-sponsored retirement systems from receiving more than one employer contribution toward health insurance coverage.

TEFRA - For Active State Employees Age Sixty-five (65) and Older

Every month, the Personnel Cabinet's Payroll Branch will generate a report of all active state employees who will turn age sixty-five (65) in the next three (3) months. OPEHI's Member Services Branch will distribute this report to appropriate Insurance Coordinators. The TEFRA letter in Appendix C should be mailed to the employees on that list. The letter details how TEFRA affects the employee and what his/her options are at age sixty-five (65).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is legislation enacted by the federal government to: ensure health insurance portability; reduce health care fraud and abuse; guarantee the integrity and confidentiality of health information; and improve the operations of the health care system.

Privacy

HIPAA specifically addresses protecting the privacy of protected health information (PHI). The government has established limitations on the sharing of PHI.

PHI is medical and demographic information that is identifiable to a specific person. Examples of PHI are an individual's address, gender, Social Security number, date of birth, diagnosis or claims history.

What is OPEHI doing to comply with HIPAA?

In the past, the OPEHI has exchanged electronic mail with members, carriers and coordinators that has contained protected health information needed to identify the member and the issue (social security number, address, etc.). Due to the need to comply with HIPAA, the OPEHI has implemented several changes designed to protect health information used in electronic mail. These changes are applicable to all programs.

When a plan member's information is being transmitted via electronic mail there are two competing interests: (1) The plan member has an expectation that the use of protected health information is limited to the minimum necessary to carry out the purpose of the communication; and (2) The employees involved in the communication have an interest in sharing the maximum amount of information permissible to expediently carry out their job function.

In addition to those concerns, electronic mail is considered a public document and is subject to open records requests. One of the OPEHI's concerns is that protected health information transmitted via electronic mail may be inadvertently disclosed to the public through an open records request.

Based on these concerns, the OPEHI has implemented the following new procedures for transmitting member information (protected health information or personally identifiable information) to carriers and coordinators via electronic mail:

Use the word "Confidential" with the member's last name in the subject line (ex. Confidential – Smith).

This procedure is necessary to ensure that the Governor's Office of Technology can identify all electronic mail to and from this office containing personally identifiable information. If an open records request is made that would include any electronic mail so marked, the request will be forwarded to the OPEHI so that the requested electronic mail may be edited before complying.

Use the member's last name and the last four (4) digits of the social security number in the text of the electronic mail message to identify the member (ex. Smith-2390). (Currently the employee identifies plan members by his/her full name and the last 4 digits of the social security number (ex. Tom Smith ____ - ____ - 2390) or first initial, last name and the last 4 digits of the social security number

(ex. T. Smith ____ - ____ -2390).) Although the abbreviated information may cause some inefficiency in communication, it is necessary to protect the information regarding members.

Include only the information necessary to resolve the issue. Currently, Insurance Coordinators send additional information that may not be relevant, including but not limited to, diagnosis, treatment, prognosis and claims issues. Since the operations of OPEHI is to procure health insurance on behalf of the Public Employee Health Insurance Program; contract with Third Party Administrators for administration of the flexible spending programs; and provide the eligibility information for both, the above listed information would not be relevant to OPEHI's scope of operations.